MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157
PHONE: (601) 957-6300

ADVANCED PRACTICE REGISTERED NURSE (APRN) MISSISSIPPI CERTIFICATION

Applicants for Mississippi Board of Nursing (Board) APRN certification **MUST** be currently licensed as a Registered Nurse in Mississippi, or hold an active unrestricted Registered Nurse Compact license, or hold a temporary permit as a Registered Nurse (RN) in Mississippi. APRNs applying for RN endorsement or RN reinstatement **and** APRN certification must complete the RN endorsement or RN reinstatement process before APRN certification can be granted.

INSTRUCTIONS:

1. **APRN CERTIFICATION APPLICATION:** Type in form and make selections. Print completed form to sign, date, and/or notarize and submit to the address above. Incomplete applications will be returned.
   - **APRN Reinstatement:** To apply for APRN reinstatement you must have once held a Mississippi APRN certification that is now lapsed. Follow instructions 1 – 7, 10 – 12, and the DEA instructions if applicable.

2. **FEES**:

APRN Certification (APRN Graduate, RN Endorsement, Compact, Reinstatement)	$100.00
Controlled Substance Prescriptive Authority (CSPA)	$100.00 *(add in addition to the fee above if applying for CSPA)*

   Make check or money order payable to the Mississippi Board of Nursing. Include your social security number on your payment. Fees are non-refundable.

3. **PRIMARY STATE OF RESIDENCY:** Indicate your primary state of residence. If your primary state of residence is a member of the Nurse Licensure Compact (NLC), you will need to provide proof of licensure in that Compact state in order to be granted APRN privilege in Mississippi. A complete listing of NLC states is available at www.ncsbn.org.

4. **APRN PRACTICE GUIDELINES**: Read the Mississippi Nursing Practice Law and 30 Mississippi Administrative Code. APRN guidelines are outlined in §73-15-20 of the Mississippi Nursing Practice Law and 30 Mississippi Administrative Code Part 2840. Accessible at www.msbn.state.ms.us, Publications.

5. **NOTARIZE**: Complete affidavit on bottom of APRN Practice Guidelines sign and have notarized. Complete and notarize the Authorization to Release information form.

6. **POPULATION FOCUS:** Indicate your area of population focus. Population focus can be family/individual across the life span, adult/gerontology, pediatric, neonatal, women's health/gender related, psychiatric/mental health.

7. **EVIDENCE OF NATIONAL APRN CERTIFICATION:** Submit current proof of national APRN certification:
   - **a.** Nationally Certified Practitioners – Submit a copy of a current certification from the national certification organization.
   - **b.** New Graduate APRN – Request evidence of certification be submitted directly to the Board of Nursing from the national certification organization.
   - **c.** Submit a copy of each additional specialty certification (i.e., first assistant, wound care, etc.)

8. **TRANSCRIPT:** Submit an official transcript from:
   - **a.** An accredited masters or higher degree program of nursing that prepares nurses for one of the APRN role designation of Certified Nurse-Midwife (CNM), Clinical Nurse Specialist (CNS), or Certified Nurse Practitioner (CNP), or Certified Registered Nurse Anesthetist (CRNA).
   - **b.** APRN applicants who graduate from a nurse practitioner program and were nationally certified as a nurse practitioner prior to December 31, 1993 may submit evidence of graduation from an accredited educational program for registered nurses.

c. APRN applicants graduating from a nurse practitioner program after December 31, 1998, will be required to submit official evidence of graduation from a graduate program with a concentration in the applicant's respective advanced practice nursing specialty.

9. **PRACTICE DOCUMENTATION NEW GRADUATE:** A new graduate APRN must submit evidence of completion of 720 hours monitored practice with either a Mississippi licensed physician or a certified APRN under direct (onsite) supervision, for the first 720 hours. A letter of completion of 720 hours signed by the APRN graduate completing the hours and signature of preceptor(s) must be submitted to the board office and must include the date of completion. Keep a log of hours in your APRN personnel records for possible audit.

10. **VERIFICATION OF PROTOCOL/PRACTICE:** Submit documentation of protocol/practice guidelines for approval (approval must be granted prior to practicing as an APRN) with application. After initial approval, with a fee prior to implementation for board approval revisions to practice sites can be made on line.

11. **PRACTICE SITE DOCUMENATION:** Submit documentation of practice site, type, and specialty. If the site, type or specialty is in pain management, weight loss, wound care, aesthetics, an emergency room, or any other specialty area submit evidence of additional training or certification in the area of specialty you are applying for board approval.

12. **COLLABORATING/CONSULTING PHYSICIAN(S):** Indicate and provide the requested information on the verification of protocol/practice for each physician with whom you have entered into a collaborative practice agreement in accordance with 30 Miss. Admin, Code, Pt. 2840, R. 2.3. It is recommended that you have a signed protocol by the APRN and collaborative physician for proof of agreement for possible audit.

13. **CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY (CSPA):** Select if you wish or do not wish to apply for CSPA. If you are applying for CSPA include an additional fee of $100.00. Every certified APRN authorized to practice in Mississippi who prescribes any controlled substances (Schedules II, III, IV, or V) within Mississippi or who proposes to engage in the prescribing of any controlled substance within Mississippi must be registered with the U.S. Drug Enforcement Administration (DEA) in compliance with Title 21 CFR Part 1301 Food and Drugs, **and** must also apply for this privilege with the Mississippi Board of Nursing. **CSPA is not automatically granted with an APRN license in Mississippi**
    a. To register with the DEA see instructions below.
    b. New graduate APRNs must submit evidence of completion of 720 hours of monitored practice with either a licensed physician or a certified APRN in a direct. See DEA registration instructions below.

REGISTRATION WITH THE U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMINISTRATION

1. **DO NOT** apply for a DEA registration prior to being issued prescriptive authority by the Mississippi Board of Nursing.
2. Register online at www.deadiversion.usdoj.gov after you have been issued prescriptive authority by the Mississippi Board of Nursing, select Registration, and Registration Applications. Pay applicable fee by Visa, MasterCard, American Express, or Discover.
3. DEA Customer Service 1-800-882-9539.
4. Information and resources, including questions and answers, are available by clicking on the "Registration Tools & Resources" section of the DEA web site.
5. When completing the DEA registration application you should enter your APRN license number. You will not have a state controlled substance number.
6. DEA will be notified by the board of nursing once CSPA has been approved.
7. Your DEA number will then (and only then) be sent to your home address directly from the DEA office.
8. Submit a copy of your DEA number and registration to the Board office.

Criminal Background Check (CBC) Registration Instructions

Miss Code Ann. Section § 73-15-17 (Q); 73-15-19; and 73-15-21, authorizes the Mississippi Board of Nursing (MSBN) to undergo a fingerprint-based criminal background history check of the Mississippi central criminal data base and the Federal Bureau of Investigations criminal history for licensure. Please follow the instructions below to complete the CBC process.

1. Complete and submit an application for licensure.

2. **CBC Registration** - Complete the online CBC registration at www.msbn.state.ms.us, using the exact name as used on the licensure application. If an applicant has undergone a name change different from the name on their photo identification, you must present the necessary legal documents (i.e., marriage certificate, divorce decree, or other legal name change document) as proof at the time of fingerprinting.

3. **Fee** - Submit the $75.00 fee, including processing fee, at the time of completion of the online CBC form by using a credit or debit card bearing the Visa, Discover, American Express or MasterCard logo, or electronic check. **Fees are non-refundable.**

4. **Identification** - An applicant must provide two (2) sources of identification at the time of fingerprinting, one of which being a government issued current, valid and unexpired picture identification document. A driver's license is preferred for the picture identification but in the absence of a driver's license, a state-issued identification card may be acceptable. Other forms of identification documents may include: School issued student ID, State Government Issued Certificate of Birth, U.S. Active Duty/Retiree/Reservist Military Identification Card (000 10-2), U.S. Passport, Federal Government Personal Identity Verification Card (PIV), U.S. Tribal or Bureau of Indian Affairs Identification Card, Social Security Card, Court Order for a Name Change/Divorce, Marriage Certificate (Government Certificate Issued), U.S. Government Issued Consular Report of Birth Abroad, Foreign Passport with Appropriate Immigration Documents, Certificate of Citizenship (N560), Certificate of Naturalization (N550), INS 1-688 Temporary Resident Identification Card.

   If an applicant has undergone a name change different from the name on their photo identification, you must present the necessary legal documents (i.e., marriage certificate, divorce decree, or other legal name change document) as proof at the time of fingerprinting.

5. **Fingerprinting** - Only the fingerprints and CBC performed by the MSBN will be accepted.

   APRN In-State (Mississippi) New Graduates ONLY - APRN new graduate applicants from an in-state APRN program should contact their school of nursing for the date and time scheduled for onsite fingerprinting to be performed by the MSBN staff.

   For all other applicant categories follow the instructions below for appointments.

An appointment for fingerprinting must be made with the MSBN CBC staff after online CBC registration has been completed. Allow at least 24 hours for online CBC registration to be processed before making an appointment. Refer to the confirmation of payment and registration for the steps to complete the CBC process.

6. **Records/Documents** - To expedite the licensing process, applicants who have been convicted of, pled guilty or pled no contest to any charge(s), or have charges pending against them for a felony or misdemeanor, other than a minor traffic violation in any state or jurisdiction must provide the board with the following pertinent records including but not limited to:
    - Certified copies of any and all court records
    - Expungements
    - Evidence of fines paid
    - Documents that demonstrate release of probation
    - A written detailed explanation as to the circumstances leading to each criminal offense

This information may be mailed or delivered to the board at the time of licensure application.

7. Applicants with potentially disqualifying events may be required to submit additional information as requested by the board. **MSBN staff will contact the applicanteither by phone or letter to request as needed.**

8. Applicants should NOT CALL THE BOARD REQUESTING THE RESULTS OF THEIR CBC. THIS INFORMATION WILL NOT BE GIVEN OUT OVER THE PHONE, IN PERSON, BY MAIL, and copies of CBC results will not be available through the board office.

9. Allow additional time for the CBC process to be completed because of additional follow-up by board staff. The amount of additional time required is dependent on the applicant's ability to provide necessary documents and the time required for the board to review the information. A set timeframe cannot be given.

10. A second set of prints may be requested by MSBN staff if inconsistencies associated with the original fingerprint submission cause the submission to be rejected. (Do not call MSBN to check acceptance of fingerprints. If inconsistencies are noted, board staff will contact the applicant.)

11. If an applicant disagrees with the CBC results, they must contact the Board in writing within 10 business days of notification.

ONLY THE FINGERPRINTS AND CBC PERFORMED BY
THE MISSISSIPPI BOARD OF NURSING WILL BE ACCEPTED

MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157
TELEPHONE (601) 957-6300

NON-REFUNDABLE FEE	
APRN Certification	$100.00
APRN CSPA	$100.00

APRN CERTIFICATION APPLICATION

Any statement made on this application which is false and known to be false by the applicant at the time of making such statement shall be deemed fraudulent and will subject the applicant to disciplinary proceedings which may include fines up $5000.00 and loss of licensure.

Select APRN role designation you are applying for: Select one

NAME: FIRST MIDDLE MAIDEN LAST DATE:

SOCIAL SECURITY #: MS RN LICENSE #:

ADDRESS: BOX/STREET CITY STATE ZIP CODE COUNTY

PHONE: (Home #) (Alternate #) EMAIL:

My primary state of residence is: **IF NOT** Mississippi indicate your RN LICENSE # and STATE:

BASIC NURSING EDUCATION:

Nursing School Name: Location:

Date Program Completed: Degree Earned: Select one

ADVANCED PRACTICE NURSING EDUCATION:

Nursing School Name: Location:

Date Program Completed: Degree Earned: Select one

How many years of APRN experience do you have? How many years of RN experience do you have?

Have you ever been convicted of, pled guilty or pled no contest to any charge(s), or are charges pending against you for a felony or misdemeanor, other than a minor traffic violation, in any state or jurisdiction? Select one

Have you ever been arrested or convicted for driving under the influence of drugs and/or alcohol? Select one

Have you ever been denied licensure/certification, had disciplinary action or is action pending against you by a board of nursing or any other regulatory agency or certification organization in any state or jurisdiction? Select one

Have you ever been placed on a state and/or federal abuse registry? Select one

Have you within the last five years abused drugs/alcohol or been treated for dependency to alcohol or illegal chemical substances? Select one

Have you ever been disciplined by or administratively discharged by the military? Select one

*If an answer to a question above is **"YES"** attach a detailed explanation and **certified** copies of all pertinent records, including but not limited to, any and all court and/or regulatory agency from the applicable state or jurisdiction. Allow additional time for **"YES"** answers to be reviewed.*

By my signature below, I certify that I have read and understand and the information is true and correct.

Signature: _____ Date: _____

Mississippi Board of Nursing
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157

APRN PRACTICE GUIDELINES

NAME: _____ _____ _____ _____
FIRST MIDDLE MAIDEN LAST

Read the following and select a response below:

1. I agree to adhere to the protocol for Advanced Practice Registered Nurses based on the standards and guidelines outlined in the APRN Practice Guideline sections of this document. I also agree that this document will be subject to agreement by the collaborative/consultative physician(s) and that a copy of this document and further protocols referenced in 30 Miss. Admin. Code, Pt. 2840, Chapter 2, will be on file and accessible for inspection at each practice site. The agreement with the collaborative/consultative physician(s) will be indicated by the completion of the Verification of Protocol/Practice form. A signed copy of this agreement should be made available upon request at each APRN practice site.

2. I understand that I may not prescribe any scheduled of controlled substance unless I have Board Approved Controlled Substance Prescriptive Authority and have registered with the U.S. Drug Enforcement Administration. I understand that *if* I am a **NEW APRN GRADUATE**, in addition to the above, I must complete a 720 hour monitored practice before meeting requirements to apply for controlled substance.

3. I certify that I have completed a minimum of four (4) CEUs or forty (40) contact hours related to my APRN role designation (i.e. CRNA, CNM, CNS, CNP) and population focus (i.e., family/individual across the lifespan, adult/gerontology, pediatric, neonatal, women's health/gender related, psychiatric/mental health) in the last two years and a minimum of two (2) contact hours are directly related to the administering/prescribing of controlled substances. I attest to the accuracy of the information provided and that I can supply copies of documentation confirming this information if requested. I understand that *if* I am a **NEW APRN GRADUATE** I am exempt from the CEU requirement, but must fulfill it with the next APRN renewal and here after.

4. I certify that I have a mutually reviewed and agreed upon board approved protocol or practice guidelines with a Mississippi licensed physician (or dentist for CRNAs) whose practice is compatible with my APRN national certification. The agreement is in accordance to 30 Miss. Admin. Code Pt. 2840, Chapter 2, and identifies and consists of a formal quality assurance/quality improvement program which is sufficient to provide a valid evaluation of the practice and is a valid basis for change, if any.

5. I certify that my selected practice site(s) is within my scope of practice based on my national APRN certification and compatible with my collaborative/consultative physician agreement.

MAKE A SELECTION: Select one

Any statement made on this application which is false or known to be false by the applicant at the time of making such statements shall be deemed fraudulent and will subject the applicant to disciplinary proceedings which may include fine up to $5,000 and/or loss of licensure.

By my signature below, I certify that I have read and understand the above APRN Practice Guidelines.

Signature: _____ Date: _____

AFFIDAVIT

Being duly sworn states that he/she is the person referred to in the foregoing application for licensure as an advanced practice registered nurse in the State of Mississippi; that the statements herein contained are true to the best of his/her knowledge and belief; that he/she has complied with all requirements of the Law; that he/she has read and understands this Affidavit.

Signature of Applicant _____ (SEAL)

Sworn to and ascribed before me on this _____day of _____ month_____ year

Signature of Notary Public _____ My commission expires: _____

Mississippi Board of Nursing
713 Pear Orchard Road, Suite 300

Mississippi Board of Nursing
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157

VERIFICATION OF PROTOCOL/PRACTICE COLLABORATION

Any statement made on this application which is false or known to be false by the applicant at the time of making such statements shall be deemed fraudulent and will subject the applicant to disciplinary proceedings which may include fine up to $5,000 and/or loss of licensure.

NAME: FIRST | MIDDLE | MAIDEN | LAST DATE: mm/dd/yyyy

ADDRESS: BOX/STREET | CITY | STATE | ZIP CODE | COUNTY

MS RN LICENSE #:

Select Reason for Submitting this Form: Select one

PRACTICE INFORMATION

1. Select APRN role designation: Select one
2. Select population focus *if* your APRN role is CNP or CNS: Select one
3. List the following APRN certification information:

Certification #	Name of National Certifying Organization	Type of Certification	Issue Date	Expiration Date

4. List any other certification(s) applicable to your APRN role
5. List APRN specialty area(s)

CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY (CSPA)

If you choose to apply for CSPA you must enclose an additional $100.00 fee.

Select one: Select one

Have you ever had a DEA number? Select one If yes, provide a copy of current DEA registration and list all numbers ever used

DEA number | DEA Issue Date | DEA Expiration Date

COLLABORATIVE/CONSULTATIVE PRACTICE AGREEMENT

I, _____, certify that the physicians, sites, specialty and other information provided is correct and that physicians identified below have entered into a collaborative/consultative practice agreement with me in accordance with Miss. Admin. Code, Pt. 2840, R 2.3.

Date Protocol/Practice Guidelines and Collaborative/Consultative Agreement mutually agreed upon

_____ Print APRN Applicant Name

_____ Signature of APRN Applicant

_____ Date

Mississippi Board of Nursing
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157

OFFICE USE ONLY
Authorized Signature from Mississippi Board of Nursing

_____ Date _____

____ Approved ____ Denied

VERIFICATION OF PROTOCOL/PRACTICE COLLABORATION

Complete the boxes below with the information required. If you have more practice sites than available space provided, please use/print additional verification of protocol/practice collaboration sheets as needed. Do not return blank sheets.

Indicate Name of APRN Practice Site

Indicate APRN Practice Site Address

Street

City State Zip County

APRN Contact #

Describe Type of APRN Practice

If practice site is a clinic, select type

Select one

Physician Name:

Physician Practice Site Address

Street

City State Zip County

Physician MS License #

Physician primary area of practice

Physician additional area(s) of practice

Physician Contact #:

Indicate Name of APRN Practice Site

Indicate APRN Practice Site Address

Street

City State Zip County

APRN Contact #

Describe Type of APRN Practice

If practice site is a clinic, select type

Select one

Physician Name:

Physician Practice Site Address

Street

City State Zip County

Physician MS License #

Physician primary area of practice

Physician additional area(s) of practice

Physician Contact #:

Indicate Name of APRN Practice Site

Indicate APRN Practice Site Address

Street

City State Zip County

APRN Contact #

Describe Type of APRN Practice

If practice site is a clinic, select type

Select one

Physician Name:

Physician Practice Site Address

Street

City State Zip County

Physician MS License #

Physician primary area of practice

Physician additional area(s) of practice

Physician Contact #:

Mississippi Board of Nursing
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157

OFFICE USE ONLY
Authorized Signature from Mississippi Board of Nursing

_____ Date _____

____ Approved ____ Denied

VERIFICATION OF PROTOCOL/PRACTICE COLLABORATION

Complete the boxes below with the information required. If you have more practice sites than available space provided, please use/print additional verification of protocol/practice collaboration sheets as needed. Do not return blank sheets.

Indicate Name of APRN Practice Site

Indicate APRN Practice Site Address

Street

City State Zip County

APRN Contact #

Describe Type of APRN Practice

If practice site is a clinic, select type

Select one

Physician Name:

Physician Practice Site Address

Street

City State Zip County

Physician MS License #

Physician primary area of practice

Physician additional area(s) of practice

Physician Contact #:

Indicate Name of APRN Practice Site

Indicate APRN Practice Site Address

Street

City State Zip County

APRN Contact #

Describe Type of APRN Practice

If practice site is a clinic, select type

Select one

Physician Name:

Physician Practice Site Address

Street

City State Zip County

Physician MS License #

Physician primary area of practice

Physician additional area(s) of practice

Physician Contact #:

Indicate Name of APRN Practice Site

Indicate APRN Practice Site Address

Street

City State Zip County

APRN Contact #

Describe Type of APRN Practice

If practice site is a clinic, select type

Select one

Physician Name:

Physician Practice Site Address

Street

City State Zip County

Physician MS License #

Physician primary area of practice

Physician additional area(s) of practice

Physician Contact #:

MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157
Telephone (601) 957-6300

AUTHORIZATION TO RELEASE INFORMATION

Please read the following release form carefully. Enter your name in the blanks and your signature, and the date in the designated spaces. **THIS FORM MUST BE NOTARIZED AND SHOULD ONLY BE SUBMITTED WITH YOUR INTIIAL APPLICATION**.

TO WHOM IT MAY CONCERN:

I, _____, hereby authorize any and all individuals and entities to release to the Mississippi Board of Nursing and its staff, personnel and/or agents, ***any and all records and information***, whether it be academic, military, medical, psychiatric, psychological, drug/alcohol treatment, employment (including, but not limited to, applications for employment, payroll information, incident reports, drug screens, alcohol screens, contracts for employment, dates and hours worked, dates and hours of absences, reasons for days missed, appraisals and reprimands, promotions, complaints, identity of supervisors, illnesses, injuries, and my reasons for termination or leaving), judicial (including, but not limited to, investigatory agency and court criminal and civil records), or personal reference, and I, _____, being competent to grant this release, ***hereby fully authorize the release of any and all such information, privileged or otherwise***, to the **Mississippi Board of Nursing** and its staff, personnel, representatives and/or agents and fully release any and all persons or parties from any and all charges or liability whatsoever because of furnishing or releasing said information and/or documents. I further authorize the Mississippi Board of Nursing to release any and all information, including but not limited to, the above referenced records to individuals/entities the Mississippi Board of Nursing deems necessary. This release shall remain in full force and effect until revoked in writing.

SIGNATURE:_____

PRINTED NAME:_____

SOCIAL SECURITY NUMBER:_____

DATE:_____

ATTORNEY'S SIGNATURE:_____
(if applicable)

STATE OF _____COUNTY OF _____

Personally came and appeared before me, the undersigned authority in and for said county and state, the within named _____, who acknowledged to me that he/she signed and delivered the above and foregoing Authorization to Release Information form on the date therein mentioned and for the purpose therein expressed.

Given under my hand and seal of office, this the _____day of _____month _____year.

_____ _____
NOTARY PUBLIC MY COMMISSION EXPIRES

SEAL

Form # RI15 04/2010